Exhibit 28

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

CARRIER

PICA

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22C415636

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [X] F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State) MI

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 02/25/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 11 08 10 INJURY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: SAUL WEINGARDEN

17a

17b. NPI 1760459994

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 847.0
2. 840.9
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	12 10 10 | 12 10 10	11		97003	GO	12	225.00	1		NPI	MEGAN RUTLEDGE
2	12 10 10 | 12 10 10	11		97535	GO	12	70.00	1		NPI	MEGAN RUTLEDGE
3	12 10 10 | 12 10 10	11		97110	GO	12	75.00	1		NPI	MEGAN RUTLEDGE
4	12 10 10 | 12 10 10	11		97140	GO	12	65.00	1		NPI	MEGAN RUTLEDGE
5	12 10 10 | 12 10 10	11		97035	GO	12	60.00	1		NPI	MEGAN RUTLEDGE
6	12 10 10 | 12 10 10	11		97014	GO	12	55.00	1		NPI	MEGAN RUTLEDGE

25. FEDERAL TAX I.D. NUMBER: 27-1033080 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: CHAJO000 1286

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO

28. TOTAL CHARGE: $ 550.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 550.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

02/25/11

SIGNED MEGAN RUTLEDGE OTR DATE

32. SERVICE FACILITY LOCATION INFORMATION
POINTE PHYSICAL THERAPY
17200 E.10 MILE RD.
EASTPOINTE, MI 48021
a. 1285954107 b

33. BILLING PROVIDER INFO & PH. # (586) 774-5006
POINTE PHYSICAL THERAPY
17200 E. 10 MILE SUITE 165
EASTPOINTE MI 48021
a. 1285954107 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

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	8. PATIENT STATUS Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	
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a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH SEX M [X] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? [X] YES [ ] NO PLACE (State) MI	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes*, return to and complete Item 9 a-d.

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SAUL WEINGARDEN	17a. 17b. NPI 1760459994	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 847.0 2. 840.9 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	12 10 10 12 10 10	11		97010	GO	12	55.00	1			MEGAN RUTLEDGE NPI
2	12 17 10 12 17 10	11		97010	GO	12	55.00	1			MEGAN RUTLEDGE NPI
3	12 17 10 12 17 10	11		97014	GO	12	55.00	1			MEGAN RUTLEDGE NPI
4	12 17 10 12 17 10	11		97035	GO	12	60.00	1			MEGAN RUTLEDGE NPI
5	12 17 10 12 17 10	11		97140	GO	12	65.00	1			MEGAN RUTLEDGE NPI
6	12 17 10 12 17 10	11		97110	GO	12	75.00	1			MEGAN RUTLEDGE NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
27-1033080 [ ] [X]	CHAJ0000 1286	[X] YES [ ] NO	$ 365.00	$	$ 365.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 02/25/11 MEGAN RUTLEDGE OTR SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION POINTE PHYSICAL THERAPY 17200 E.10 MILE RD. EASTPOINTE, MI 48021 a. 1285954107 b.	33. BILLING PROVIDER INFO & PH # (586)774-5006 POINTE PHYSICAL THERAPY 17200 E. 10 MILE SUITE 165 EASTPOINTE MI 48021 a. 1285954107 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

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APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

STATE FARM INSURANCE
P.O. BOX 2361
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CARRIER

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APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22C415636

2. PATIENT'S NAME (Last Name, First Name, Middle Initial):

3. PATIENT'S BIRTH DATE: SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street):

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): MI

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: SAUL WEINGARDEN

17a.

17b. NPI: 1760459994

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20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 847.9
2.
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1 12 10 10	12 10 10	11		97001	GP	1	225.00	1		NPI	MANAS BASTHA
2 12 10 10	12 10 10	11		97010	GP	1	55.00	1		NPI	MANAS BASTHA
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25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
27-1033080		X	CHAJO000 1285	YES [X] NO [ ]	$ 515.00	$	$ 515.00

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02/25/11
SIGNED: MANAS BASTHA RPT DATE:

32. SERVICE FACILITY LOCATION INFORMATION
POINTE PHYSICAL THERAPY
17200 E.10 MILE RD.
EASTPOINTE, MI 48021
a. 1285954107 b.

33. BILLING PROVIDER INFO & PH. # (586)774-5006
POINTE PHYSICAL THERAPY
17200 E. 10 MILE SUITE 165
EASTPOINTE MI 48021
a. 1285954107 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-BW / WHCF-10-BW-SS

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WCMS-1500CS

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HEALTH INSURANCE CLAIM FORM

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b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): MI

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

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										NPI	
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PHYSICIAN OR SUPPLIER INFORMATION

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27-1033080	[X]	CHAJO000 1286	YES [X] NO [ ]	$ 70.00	$	$ 70.00

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		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 12 17 10 12 17 10	11		97110	GP	1	75.00	1		NPI	MANAS BASTHA
2 01 21 11 01 21 11	11		97010	GP	1	55.00	1		NPI	JUSTES GEORGE
3 01 21 11 01 21 11	11		97014	GP	1	55.00	1		NPI	JUSTES GEORGE
4 01 21 11 01 21 11	11		97035	GP	1	60.00	1		NPI	JUSTES GEORGE
5 01 21 11 01 21 11	11		97124	GP	1	60.00	1		NPI	JUSTES GEORGE
6 01 21 11 01 21 11	11		97110	GP	1	75.00	1		NPI	JUSTES GEORGE

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
27-1033080 [ ] [X]	CHAJO000 1285	[X] YES [ ] NO	$ 380.00	$	$ 380.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (586) 774-5006
02/25/11	POINTE PHYSICAL THERAPY 17200 E.10 MILE RD. EASTPOINTE, MI 48021	POINTE PHYSICAL THERAPY 17200 E. 10 MILE SUITE 165 EASTPOINTE MI 48021
SIGNED JUSTES GEORGE RPT DATE	a. 1285954107 b.	a. 1285954107 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22C415636

2. PATIENT'S NAME (Last Name, First Name, Middle Initial):

3. PATIENT'S BIRTH DATE: SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street):

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): MI

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 02/25/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 11 08 10 INJURY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: SAUL WEINGARDEN

17a.

17b. NPI 1760459994

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 847.9

3.

2.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 21 11	01 21 11	11		97002	GP	1	150.00	1		NPI	JUSTES GEORGE
2 01 28 11	01 28 11	11		97010	GP	1	55.00	1		NPI	JUSTES GEORGE
3 01 28 11	01 28 11	11		97014	GP	1	55.00	1		NPI	JUSTES GEORGE
4 01 28 11	01 28 11	11		97035	GP	1	60.00	1		NPI	JUSTES GEORGE
5 01 28 11	01 28 11	11		97124	GP	1	60.00	1		NPI	JUSTES GEORGE
6 01 28 11	01 28 11	11		97110	GP	1	75.00	1		NPI	JUSTES GEORGE

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 27-1033080 [X]

26. PATIENT'S ACCOUNT NO.: CHAJO000 1285

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 455.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 455.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

02/25/11

SIGNED JUSTES GEORGE RPT DATE

32. SERVICE FACILITY LOCATION INFORMATION
POINTE PHYSICAL THERAPY
17200 E.10 MILE RD.
EASTPOINTE, MI 48021

a. 1285954107 b.

33. BILLING PROVIDER INFO & PH. # (586) 774-5006
POINTE PHYSICAL THERAPY
17200 E. 10 MILE SUITE 165
EASTPOINTE MI 48021

a. 1285954107 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

SECOND FOLD

FIRST FOLD WHOF-10-ENV / WHCF-10-ENV-SS

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22C415636

2. PATIENT'S NAME (Last Name, First Name, Middle Initial):

3. PATIENT'S BIRTH DATE: SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street):

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY:

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP:

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY): SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): MI

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 03/29/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 11 08 10 INJURY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: SAUL WEINGARDEN

17a.

17b. NPI: 1760459994

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 847.0
2. 840.9
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23 PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 21 11	01 21 11	11		97010	GO	12	55.00	1		NPI	MEGAN RUTLEDGE
2 01 21 11	01 21 11	11		97014	GO	12	55.00	1		NPI	MEGAN RUTLEDGE
3 01 21 11	01 21 11	11		97035	GO	12	60.00	1		NPI	MEGAN RUTLEDGE
4 01 21 11	01 21 11	11		97140	GO	12	65.00	1		NPI	MEGAN RUTLEDGE
5 01 21 11	01 21 11	11		97110	GO	12	75.00	1		NPI	MEGAN RUTLEDGE
6 01 21 11	01 21 11	11		97535	GO	12	70.00	1		NPI	MEGAN RUTLEDGE

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 27-1033080 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: CHAJO000 1412

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 380.00

29. AMOUNT PAID:

30. BALANCE DUE: $ 380.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

03/29/11

MEGAN RUTLEDGE OTR

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

POINTE PHYSICAL THERAPY
17200 E.10 MILE RD.
EASTPOINTE, MI 48021

a. 1285954107 b.

33. BILLING PROVIDER INFO & PH. # (586)774-5006

POINTE PHYSICAL THERAPY
17200 E. 10 MILE SUITE 165
EASTPOINTE MI 48021

a. 1285954107 b.

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APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22C415636

2. PATIENT'S NAME (Last Name, First Name, Middle Initial):

3. PATIENT'S BIRTH DATE: SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street):

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY:

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

ZIP:

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH: MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): MI

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 03/29/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 11 08 10 — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): INJURY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: SAUL WEINGARDEN

17a.

17b. NPI 1760459994

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 847.0
2. 840.9
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 28 11	01 28 11	11		97010	GO	12	55.00	1		NPI	MEGAN RUTLEDGE
2 01 28 11	01 28 11	11		97014	GO	12	55.00	1		NPI	MEGAN RUTLEDGE
3 01 28 11	01 28 11	11		97035	GO	12	60.00	1		NPI	MEGAN RUTLEDGE
4 01 28 11	01 28 11	11		97140	GO	12	65.00	1		NPI	MEGAN RUTLEDGE
5 01 28 11	01 28 11	11		97110	GO	12	75.00	1		NPI	MEGAN RUTLEDGE
6 01 28 11	01 28 11	11		97535	GO	12	70.00	1		NPI	MEGAN RUTLEDGE

25. FEDERAL TAX I.D. NUMBER: 27-1033080 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: CHAJO000 1412

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 380.00

29. AMOUNT PAID:

30. BALANCE DUE: $ 380.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

03/29/11

MEGAN RUTLEDGE OTR

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

POINTE PHYSICAL THERAPY
17200 E.10 MILE RD.
EASTPOINTE, MI 48021

a. 1285954107 b.

33. BILLING PROVIDER INFO & PH. # (586) 774-5006

POINTE PHYSICAL THERAPY
17200 E. 10 MILE SUITE 165
EASTPOINTE MI 48021

a. 1285954107 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

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WCMS-1500CS

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P.O. BOX 2361
BLOOMINGTON, IL 61702

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER — (Medicare #) / (Medicaid #) / (Sponsor's SSN) / (Member ID#) / (SSN or ID) / (SSN) / (ID) — OTHER: X	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22C415636	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE / SEX: M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE / ZIP CODE / TELEPHONE (Include Area Code)	8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student	CITY / STATE / ZIP CODE / TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES / X NO	a. INSURED'S DATE OF BIRTH / SEX: M X F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX: M F	b. AUTO ACCIDENT? X YES NO PLACE (State): MI	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / X NO — *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

SECOND FOLD

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 03/29/11

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SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY: 11 08 10 — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): INJURY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: SAUL WEINGARDEN	17a. 17b. NPI: 1760459994	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line): 1. 847.0 2. 840.9 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
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2 02 09 11 02 09 11	11		97014	GO	12	55.00	1		NPI	MEGAN RUTLEDGE
3 02 09 11 02 09 11	11		97035	GO	12	60.00	1		NPI	MEGAN RUTLEDGE
4 02 09 11 02 09 11	11		97140	GO	12	65.00	1		NPI	MEGAN RUTLEDGE
5 02 09 11 02 09 11	11		97110	GO	12	75.00	1		NPI	MEGAN RUTLEDGE
6 02 09 11 02 09 11	11		97535	GO	12	70.00	1		NPI	MEGAN RUTLEDGE

25. FEDERAL TAX I.D. NUMBER: 27-1033080 SSN EIN X	26. PATIENT'S ACCOUNT NO.: CHAJO000 1412	27. ACCEPT ASSIGNMENT? (govt. claims, see back) X YES NO	28. TOTAL CHARGE: $ 380.00	29. AMOUNT PAID	30. BALANCE DUE: $ 380.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
03/29/11
MEGAN RUTLEDGE OTR
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
POINTE PHYSICAL THERAPY
17200 E.10 MILE RD.
EASTPOINTE, MI 48021
a. 1285954107 b.

33. BILLING PROVIDER INFO & PH. # (586) 774-5006
POINTE PHYSICAL THERAPY
17200 E. 10 MILE SUITE 165
EASTPOINTE MI 48021
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APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22C415636

2. PATIENT'S NAME (Last Name, First Name, Middle Initial):

3. PATIENT'S BIRTH DATE: SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street):

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):
CITY:
ZIP:

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): MI

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 03/29/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 11 08 10 — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): INJURY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: SAUL WEINGARDEN
17a.
17b. NPI 1760459994

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)
1. 847.9
2.
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 02 09 11	02 09 11	11		97010	GP	1	55.00	1		NPI	JUSTES GEORGE
2 02 09 11	02 09 11	11		97014	GP	1	55.00	1		NPI	JUSTES GEORGE
3 02 09 11	02 09 11	11		97035	GP	1	60.00	1		NPI	JUSTES GEORGE
4 02 09 11	02 09 11	11		97124	GP	1	60.00	1		NPI	JUSTES GEORGE
5 02 09 11	02 09 11	11		97110	GP	1	75.00	1		NPI	JUSTES GEORGE
6 02 17 11	02 17 11	11		97010	GP	1	55.00	1		NPI	JUSTES GEORGE

25. FEDERAL TAX I.D. NUMBER: 27-1033080 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: CHAJO000 1413

27. ACCEPT ASSIGNMENT? (govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 360.00

29. AMOUNT PAID:

30. BALANCE DUE: $ 360.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
03/29/11
JUSTES GEORGE RPT
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
POINTE PHYSICAL THERAPY
17200 E.10 MILE RD.
EASTPOINTE, MI 48021
a. 1285954107 b.

33. BILLING PROVIDER INFO & PH. # (586)774-5006
POINTE PHYSICAL THERAPY
17200 E. 10 MILE SUITE 165
EASTPOINTE MI 48021
a. 1285954107 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
	22C415636	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY	8. PATIENT STATUS Single [ ] Married [ ] Other [ ]	CITY
ZIP	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH SEX M [X] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State) MI	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 03/29/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 11 08 10 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: SAUL WEINGARDEN	17a. 17b. NPI 1760459994	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24E by Line) 1. 847.0 2. 840.9 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 02 17 11	02 17 11	11		97010	GO	12	55.00	1		NPI	MEGAN RUTLEDGE
2 02 17 11	02 17 11	11		97014	GO	12	55.00	1		NPI	MEGAN RUTLEDGE
3 02 17 11	02 17 11	11		97035	GO	12	60.00	1		NPI	MEGAN RUTLEDGE
4 02 17 11	02 17 11	11		97140	GO	12	65.00	1		NPI	MEGAN RUTLEDGE
5 02 17 11	02 17 11	11		97110	GO	12	75.00	1		NPI	MEGAN RUTLEDGE
6 02 17 11	02 17 11	11		97535	GO	12	70.00	1		NPI	MEGAN RUTLEDGE

25. FEDERAL TAX I.D. NUMBER SSN EIN: 27-1033080 [X]	26. PATIENT'S ACCOUNT NO.: CHAJO000 1412	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE: $ 380.00	29. AMOUNT PAID	30. BALANCE DUE: $ 380.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
03/29/11
MEGAN RUTLEDGE OTR
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
POINTE PHYSICAL THERAPY
17200 E.10 MILE RD.
EASTPOINTE, MI 48021
a. 1285954107 b

33. BILLING PROVIDER INFO & PH. # (586)774-5006
POINTE PHYSICAL THERAPY
17200 E. 10 MILE SUITE 165
EASTPOINTE MI 48021
a. 1285954107 b

PATIENT AND INSURED INFORMATION | PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD | FIRST FOLD WHCF-10-ENV / WHCS-10-ENV-SS

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	X
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	22C415636
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE / SEX	M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	
6. PATIENT RELATIONSHIP TO INSURED	Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street)	
8. PATIENT STATUS	Single Married Other / Employed Full-Time Student Part-Time Student
CITY / ZIP	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO:	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
a. EMPLOYMENT? (Current or Previous)	YES / X NO
a. INSURED'S DATE OF BIRTH / SEX	M X F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX	M F
b. AUTO ACCIDENT? / PLACE (State)	X YES NO MI
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	
c. OTHER ACCIDENT?	YES / X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	STATE FARM INSURANCE
d. INSURANCE PLAN NAME OR PROGRAM NAME	
10d. RESERVED FOR LOCAL USE	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	YES / X NO — *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 03/29/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	11 08 10 INJURY
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	SAUL WEINGARDEN
17a. / 17b. NPI	1760459994
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO	
19. RESERVED FOR LOCAL USE	
20. OUTSIDE LAB? / $ CHARGES	YES X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)	1. 847.9 2. 3. 4.
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER	

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 02 17 11	02 17 11	11		97014	GP	1	55.00	1		NPI	JUSTES GEORGE
2 02 17 11	02 17 11	11		97035	GP	1	60.00	1		NPI	JUSTES GEORGE
3 02 17 11	02 17 11	11		97140	GP	1	65.00	1		NPI	JUSTES GEORGE
4 02 24 11	02 24 11	11		97010	GP	1	55.00	1		NPI	JUSTES GEORGE
5 02 24 11	02 24 11	11		97014	GP	1	55.00	1		NPI	JUSTES GEORGE
6 02 24 11	02 24 11	11		97035	GP	1	60.00	1		NPI	JUSTES GEORGE

25. FEDERAL TAX I.D. NUMBER / SSN EIN	27-1033080 / X	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (govt. claims, see back)	28. TOTAL CHARGE / 29. AMOUNT PAID / 30. BALANCE DUE
		CHAJO000 1413	X YES NO	$ 350.00 / $ 350.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
03/29/11
JUSTES GEORGE RPT
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
POINTE PHYSICAL THERAPY
17200 E.10 MILE RD.
EASTPOINTE, MI 48021
a. 1285954107 b.

33. BILLING PROVIDER INFO & PH. # (586)774-5006
POINTE PHYSICAL THERAPY
17200 E. 10 MILE SUITE 165
EASTPOINTE MI 48021
a. 1285954107 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
	22C415636	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
C	8. PATIENT STATUS Single Married Other	CI
Z	Employed Full-Time Student Part-Time Student	ZIP
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH SEX M X F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? X YES NO PLACE (State) MI	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
		STATE FARM INSURANCE
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes*, return to and complete item 9 a-d.

SECOND FOLD

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 03/29/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 11 08 10 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SAUL WEINGARDEN	17a 17b. NPI 1760459994	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 847.0 2. 840.9 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 02 24 11 02 24 11	11		97010	GO	12	55.00	1		NPI	MEGAN RUTLEDGE
2 02 24 11 02 24 11	11		97014	GO	12	55.00	1		NPI	MEGAN RUTLEDGE
3 02 24 11 02 24 11	11		97035	GO	12	60.00	1		NPI	MEGAN RUTLEDGE
4 02 24 11 02 24 11	11		97140	GO	12	65.00	1		NPI	MEGAN RUTLEDGE
5 02 24 11 02 24 11	11		97110	GO	12	75.00	1		NPI	MEGAN RUTLEDGE
6 02 24 11 02 24 11	11		97535	GO	12	70.00	1		NPI	MEGAN RUTLEDGE

25. FEDERAL TAX I.D. NUMBER SSN EIN X	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE $ 380.00	29. AMOUNT PAID $	30. BALANCE DUE $ 380.00
27-1033080	CHAJO000 1412				

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 03/29/11 MEGAN RUTLEDGE OTR SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION POINTE PHYSICAL THERAPY 17200 E.10 MILE RD. EASTPOINTE, MI 48021 a. 1285954107 b.	33. BILLING PROVIDER INFO & PH. # (586)774-5006 POINTE PHYSICAL THERAPY 17200 E. 10 MILE SUITE 165 EASTPOINTE MI 48021 a. 1285954107 b.

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APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
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2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
C	8. PATIENT STATUS Single Married Other	CITY
Z	Employed Full-Time Student Part-Time Student	ZIP
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH SEX M X F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? X YES NO PLACE (State) MI	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes*, return to and complete item 9 a-d.

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SIGNED SIGNATURE ON FILE DATE 03/29/11

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SIGNED SIGNATURE ON FILE

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY 11 08 10 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY	15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SAUL WEINGARDEN	17a. 17b NPI 1760459994	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 847.9 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF NO 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 02 24 11	02 24 11	11		97140	GP	1	65.00	1		NPI	JUSTES GEORGE
2 02 24 11	02 24 11	11		97110	GP	1	75.00	1		NPI	JUSTES GEORGE
3 02 25 11	02 25 11	11		97010	GP	1	55.00	1		NPI	JUSTES GEORGE
4 02 25 11	02 25 11	11		97014	GP	1	55.00	1		NPI	JUSTES GEORGE
5 02 25 11	02 25 11	11		97035	GP	1	60.00	1		NPI	JUSTES GEORGE
6 02 25 11	02 25 11	11		97140	GP	1	65.00	1		NPI	JUSTES GEORGE

25. FEDERAL TAX I.D. NUMBER SSN EIN 27-1033080 X	26. PATIENT'S ACCOUNT NO. CHAJO000 1413	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE $ 375.00	29. AMOUNT PAID	30. BALANCE DUE $ 375.00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 03/29/11 JUSTES GEORGE RPT SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION POINTE PHYSICAL THERAPY 17200 E.10 MILE RD. EASTPOINTE, MI 48021 a. 1285954107 b.		33. BILLING PROVIDER INFO & PH. # (586)774-5006 POINTE PHYSICAL THERAPY 17200 E. 10 MILE SUITE 165 EASTPOINTE MI 48021 a. 1285954107 b.		

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) / (Medicaid #) / (Sponsor's SSN) / (Member ID#) / (SSN or ID) / (SSN) / X (ID)	22C415636
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX: M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street) C Zi	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street) CITY ZIP	
	8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO
a. INSURED'S DATE OF BIRTH SEX: M X F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M F	b. AUTO ACCIDENT? X YES NO PLACE (State) MI
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes,* return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 03/29/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
11 08 10 INJURY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: SAUL WEINGARDEN	17a. 17b. NPI 1760459994	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 847.0 2. 840.9 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 02 25 11	02 25 11	11		97010	GO	12	55.00	1		NPI	MEGAN RUTLEDGE
2 02 25 11	02 25 11	11		97014	GO	12	55.00	1		NPI	MEGAN RUTLEDGE
3 02 25 11	02 25 11	11		97035	GO	12	60.00	1		NPI	MEGAN RUTLEDGE
4 02 25 11	02 25 11	11		97140	GO	12	65.00	1		NPI	MEGAN RUTLEDGE
5 02 25 11	02 25 11	11		97110	GO	12	75.00	1		NPI	MEGAN RUTLEDGE
6 02 25 11	02 25 11	11		97535	GO	12	70.00	1		NPI	MEGAN RUTLEDGE

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
27-1033080	X	CHAJO000 1412	X YES NO	$ 380.00		$ 380.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (586) 774-5006
03/29/11 MEGAN RUTLEDGE OTR SIGNED DATE	POINTE PHYSICAL THERAPY 17200 E.10 MILE RD. EASTPOINTE, MI 48021 a. 1285954107 b.	POINTE PHYSICAL THERAPY 17200 E. 10 MILE SUITE 165 EASTPOINTE MI 48021 a. 1285954107 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

STATE FARM INSURANCE
P.O. BOX 2361
BLOOMINGTON, IL 61702

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22C415636

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE | SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | ZIP

8. PATIENT STATUS: Single | Married | Other | Employed | Full-Time Student | Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES | X NO

a. INSURED'S DATE OF BIRTH | SEX: M X F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M F

b. AUTO ACCIDENT? X YES | NO | PLACE (State): MI

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | X NO — if yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 03/29/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY: 11 08 10 | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): INJURY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: SAUL WEINGARDEN

17a.

17b. NPI: 1760459994

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | X NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 847.9
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	02 25 11 | 02 25 11	11		97110	GP	1	75.00	1		NPI	JUSTES GEORGE
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 27-1033080 | SSN | EIN X

26. PATIENT'S ACCOUNT NO.: CHAJO000 1413

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES | NO

28. TOTAL CHARGE: $ 75.00

29. AMOUNT PAID

30. BALANCE DUE: $ 75.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

03/29/11

JUSTES GEORGE RPT
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

POINTE PHYSICAL THERAPY
17200 E.10 MILE RD.
EASTPOINTE, MI 48021

a. 1285954107 b.

33. BILLING PROVIDER INFO & PH. # (586)774-5006

POINTE PHYSICAL THERAPY
17200 E. 10 MILE SUITE 165
EASTPOINTE MI 48021

a. 1285954107 b

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SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

STATE FARM INSURANCE
PO BOX 661023
DALLAS, TX 75266

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22C457642

2. PATIENT'S NAME (Last Name, First Name, Middle Initial):

3. PATIENT'S BIRTH DATE SEX:

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street):

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): MI

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 11/04/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 05 09 11 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: TERRY REZNICK D.O.

17a.

17b. NPI 1295874451

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)
1. 847.9
2.
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08 12 11	08 12 11	11		97032	GP	1	60:00	1		NPI	SONI
2 08 12 11	08 12 11	11		97140	GP	1	60:00	1		NPI	SONI
3 08 12 11	08 12 11	11		97116	GP	1	60:00	1		NPI	SONI
4 08 12 11	08 12 11	11		97110	GP	1	75:00	1		NPI	SONI
5 08 15 11	08 15 11	11		97010	GP	1	60:00	1		NPI	SONI
6 08 15 11	08 15 11	11		97032	GP	1	60:00	1		NPI	SONI

25. FEDERAL TAX I.D. NUMBER: 80-0503391 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: SCOPA000 1358

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 375:00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 375:00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
09/19/11
SONI
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION:
NEW ERA PT SERVICES
G 4007 W. COURT ST. SUITE G2
FLINT, MI 48532
a. 1336469139 b.

33. BILLING PROVIDER INFO & PH. #: (810)230-0444
NEW ERA PT SERVICES
G 4007 W. COURT ST. SUITE G2
FLINT MI 48532
a. 1336469139 b.

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APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

STATE FARM INSURANCE
PO BOX 661023
DALLAS, TX 75266

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
						X	22C457642		

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
	Self X Spouse Child Other	
	8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student	

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M F X
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? X YES NO PLACE (State) MI	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 12/29/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
05 09 11 INJURY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: TERRY REZNICK D.O.	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
	17b. NPI 1295874451	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)
1. 8470 3.
2. 847.1 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID #
1 08 10 11 08 10 11	11		97110	GO	12	75.00	1		NPI	RUTLEDGE
2 08 10 11 08 10 11	11		97535	GO	12	65.00	1		NPI	RUTLEDGE
3 08 15 11 08 15 11	11		97010	GO	12	60.00	1		NPI	RUTLEDGE
4 08 15 11 08 15 11	11		97014	GO	12	55.00	1		NPI	RUTLEDGE
5 08 15 11 08 15 11	11		97124	GO	12	60.00	1		NPI	RUTLEDGE
6 08 15 11 08 15 11	11		97110	GO	12	75.00	1		NPI	RUTLEDGE

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
80-0503391 X	SCOPA000 1430	X YES NO	$ 390.00	$	$ 390.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. #
11/11/10 RUTLEDGE SIGNED DATE	NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT, MI 48532 a. 1336469139 b.	(810)230-0444 NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT MI 48532 a. 1336469139 b.

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WCMS-1500CS

KMRPPT0066511

SECOND FOLD — FIRST FOLD WMCF-10-ENV / WMCF-10-ENV-SS

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

STATE FARM INSURANCE
PO BOX 661023
DALLAS, TX 75266

1500
HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22C457642

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY / SEX

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] / Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY / SEX: M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): MI

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 11/04/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 05 09 11 INJURY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: TERRY REZNICK D.O.

17a.

17b. NPI 1295874451

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)
1. 847.9
2.
3.
4.

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08 15 11	08 15 11	11		97140	GP	1	60 00	1		NPI	SONI
2 08 15 11	08 15 11	11		97116	GP	1	60 00	1		NPI	SONI
3 08 15 11	08 15 11	11		97110	GP	1	75 00	1		NPI	SONI
4 08 17 11	08 17 11	11		97010	GP	1	60 00	1		NPI	SONI
5 08 17 11	08 17 11	11		97032	GP	1	60 00	1		NPI	SONI
6 08 17 11	08 17 11	11		97140	GP	1	60 00	1		NPI	SONI

25. FEDERAL TAX I.D. NUMBER: 80-0503391 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: SCOPA000 1358

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 375 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 375 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
09/19/11
SONI
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
NEW ERA PT SERVICES
G 4007 W. COURT ST. SUITE G2
FLINT, MI 48532
a. 1336469139 b.

33. BILLING PROVIDER INFO & PH. # (810)230-0444
NEW ERA PT SERVICES
G 4007 W. COURT ST. SUITE G2
FLINT MI 48532
a. 1336469139 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCA-10-ENV / WHCF-10-ENV-US

STATE FARM INSURANCE
PO BOX 661023
DALLAS, TX 75266

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[ ] (Medicare #) [ ] (Medicaid #) [ ] (Sponsor's SSN) [ ] (Member ID#) [ ] (SSN or ID) [ ] (SSN) [X] (ID)	22C457642
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? [X] YES [ ] NO PLACE (State) MI
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [X] NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

7. INSURED'S ADDRESS (No., Street)
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [X]
b. EMPLOYER'S NAME OR SCHOOL NAME
c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 12/29/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
05 09 11 INJURY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: TERRY REZNICK D.O.	17a. [ ] 17b. NPI 1295874451	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line): 1. 8470 2. 847.1 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	08 15 11 08 15 11	11		97535	GO	12	65.00	1		NPI	RUTLEDGE
2	08 17 11 08 17 11	11		97010	GO	12	60.00	1		NPI	RUTLEDGE
3	08 17 11 08 17 11	11		97014	GO	12	55.00	1		NPI	RUTLEDGE
4	08 17 11 08 17 11	11		97124	GO	12	60.00	1		NPI	RUTLEDGE
5	08 17 11 08 17 11	11		97110	GO	12	75.00	1		NPI	RUTLEDGE
6	08 17 11 08 17 11	11		97535	GO	12	65.00	1		NPI	RUTLEDGE

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
80-0503391 [X]	SCOPA000 1430	[X] YES [ ] NO	$ 380.00	$	$ 380.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. #
11/11/10 RUTLEDGE SIGNED DATE	NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT, MI 48532 a. 1336469139 b.	NEW ERA PT SERVICES (810)230-0444 G 4007 W. COURT ST. SUITE G2 FLINT MI 48532 a. 1336469139 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

KMRPPT0066513

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

STATE FARM INSURANCE
PO BOX 661023
DALLAS, TX 75266

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22C457642

2. PATIENT'S NAME (Last Name, First Name, Middle Initial):

3. PATIENT'S BIRTH DATE SEX:

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street):

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): MI

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 11/04/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY: 05 09 11 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): INJURY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: TERRY REZNICK D.O.

17a.

17b. NPI: 1295874451

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to Item 24E by Line)
1. 847.9
2.
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08 17 11	08 17 11	11		97116	GP	1	60.00	1			SONI NPI
2 08 17 11	08 17 11	11		97110	GP	1	75.00	1			SONI NPI
3 08 19 11	08 19 11	11		97010	GP	1	60.00	1			SONI NPI
4 08 19 11	08 19 11	11		97032	GP	1	60.00	1			SONI NPI
5 08 19 11	08 19 11	11		97140	GP	1	60.00	1			SONI NPI
6 08 19 11	08 19 11	11		97116	GP	1	60.00	1			SONI NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN: 80-0503391 [X]

26. PATIENT'S ACCOUNT NO: SCOPA000 1358

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 375.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 375.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
09/19/11
SONI
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
NEW ERA PT SERVICES
G 4007 W. COURT ST. SUITE G2
FLINT, MI 48532
a. 1336469139 b.

33. BILLING PROVIDER INFO & PH. # (810)230-0444
NEW ERA PT SERVICES 11 22 201
G 4007 W. COURT ST. SUITE G2
FLINT MI 48532
a. 1336469139 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHOF-10-ERW / WHOF-10-ERWSS

STATE FARM INSURANCE
PO BOX 2361
BLOOMINGTON, IL 61702

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA ☐ PICA ☐

1. MEDICARE ☐ (Medicare #)	MEDICAID ☐ (Medicaid #)	TRICARE CHAMPUS ☐ (Sponsor's SSN)	CHAMPVA ☐ (Member ID#)	GROUP HEALTH PLAN ☐ (SSN or ID)	FECA BLK LUNG ☐ (SSN)	OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22-C449-799

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☒ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? ☒ YES ☐ NO PLACE (State) MI	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 07/18/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: JOHN J. HOBAN M.D.	17a. 17b. NPI 1144429762	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line): 1. 8470 3. 847.9 2. 847.1 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID #
1 05 02 11 05 02 11	11		97010	GP	123	60.00	1		NPI	SHAH
2 05 02 11 05 02 11	11		97032	GP	123	60.00	1		NPI	SHAH
3 05 02 11 05 02 11	11		97035	GP	123	60.00	1		NPI	SHAH
4 05 02 11 05 02 11	11		97140	GP	123	60.00	1		NPI	SHAH
5 05 02 11 05 02 11	11		97110	GP	123	75.00	1		NPI	SHAH
6 05 04 11 05 04 11	11		97010	GP	123	60.00	1		NPI	SHAH

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
80-0503391 ☒ ☐	BONTE000 1045	☒ YES ☐ NO	$ 375.00	$	$ 375.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (810)230-0444
01/03/11 SHAH SIGNED DATE	NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT, MI 48532 a. 1336469139 b.	NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT MI 48532 a. 1336469139 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WMCF-10-ENV / WMCF-10-ENV-SS

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

STATE FARM INSURANCE
PO BOX 2361
BLOOMINGTON, IL 61702

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) / (Medicaid #) / (Sponsor's SSN) / (Member ID#) / (SSN or ID) / (SSN) / [X] (ID)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX
	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
	7. INSURED'S ADDRESS (No., Street)
9. OTHER INSURED'S NAME (Last Name First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? [X] YES [ ] NO PLACE (State) MI
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [X] NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
	11. INSURED'S POLICY GROUP OR FECA NUMBER
	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [X] F [ ]
	b. EMPLOYER'S NAME OR SCHOOL NAME
	c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes,* return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 07/25/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
03 08 11 INJURY	MM DD YY	MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: JOHN J. HOBAN M.D.	17a. 17b. NPI 1144429762	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1,2,3 or 4 to Item 24E by Line): 1. 8470 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 02 11 05 02 11	11		97035	GO	1	60.00	1		NPI	RUTLEDGE
2 05 02 11 05 02 11	11		97140	GO	1	60.00	1		NPI	RUTLEDGE
3 05 02 11 05 02 11	11		97110	GO	1	75.00	1		NPI	RUTLEDGE
4 05 02 11 05 02 11	11		97535	GO	1	65.00	1		NPI	RUTLEDGE
5 05 04 11 05 04 11	11		97010	GO	1	60.00	1		NPI	RUTLEDGE
6 05 04 11 05 04 11	11		97014	GO	1	55.00	1		NPI	RUTLEDGE

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
80-0503391 [X]	BONTE000 1068	[X] YES [ ] NO	$ 375.00	$	$ 375.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. #
11/11/10 RUTLEDGE SIGNED DATE	NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT, MI 48532 a. 1336469139 b.	(810)230-0444 NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT MI 48532 a. 1336469139 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

KMRPPT0065350

STATE FARM INSURANCE
PO BOX 661023
DALLAS, TX 75266

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22035F930

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE SEX

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [X] YES [ ] NO PLACE (State) MI

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 10/31/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 08 19 11 INJURY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: TERRY REZNICK D.O.

17a.

17b. NPI 1295874451

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to Item 24E by Line)

1. 847.9 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08 29 11	08 29 11	11		97001	GP	1	300.00	1		NPI	SONI
2 08 29 11	08 29 11	11		97010	GP	1	60.00	1		NPI	SONI
3 08 29 11	08 29 11	11		97032	GP	1	60.00	1		NPI	SONI
4 08 29 11	08 29 11	11		97035	GP	1	60.00	1		NPI	SONI
5 09 01 11	09 01 11	11		97010	GP	1	60.00	1		NPI	SONI
6 09 01 11	09 01 11	11		97032	GP	1	60.00	1		NPI	SONI

25. FEDERAL TAX I.D. NUMBER SSN EIN: 80-0503391 [X]

26. PATIENT'S ACCOUNT NO.: JOHWI000 1343

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 600.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 600.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

09/19/11

SONI
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

NEW ERA PT SERVICES
G 4007 W. COURT ST. SUITE G2
FLINT, MI 48532

a. 1336469139 b.

33. BILLING PROVIDER INFO & PH. # (810)230-0444

NEW ERA PT SERVICES
G 4007 W. COURT ST. SUITE G2
FLINT MI 48532

a. 1336469139 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

KMRPPT0050783

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM INSURANCE
PO BOX 661023
DALLAS, TX 75266

CARRIER

PICA

PICA

1 MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22035F930

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
	M [ ] F [X]	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: M [ ] F [X]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX: M [ ] F [ ]	b. AUTO ACCIDENT? [X] YES [ ] NO PLACE (State) MI	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 10/31/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO
08 19 11 INJURY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: TERRY REZNICK D.O.	17a. / 17b. NPI 1295874451	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line): 1. 8470 2. 847.1 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 09 01 11 09 01 11	11		97003	GO	12	300 00	1		NPI	RUTLEDGE
2 09 01 11 09 01 11	11		97010	GO	12	60 00	1		NPI	RUTLEDGE
3 09 01 11 09 01 11	11		97014	GO	12	55 00	1		NPI	RUTLEDGE
4 09 01 11 09 01 11	11		97535	GO	12	65 00	1		NPI	RUTLEDGE
5 09 02 11 09 02 11	11		97010	GO	12	60 00	1		NPI	RUTLEDGE
6 09 02 11 09 02 11	11		97014	GO	12	55 00	1		NPI	RUTLEDGE

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
80-0503391 [ ] [X]	JOHWI000 1344	[X] YES [ ] NO	$ 595 00	$	$ 595 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. #
11/11/10 RUTLEDGE SIGNED DATE	NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT, MI 48532 a. 1336469139 b.	NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT MI 48532 (810)230-0444 a. 1336469139 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WMCF-10-ENV / WMCF-10-ENV-SS

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM INSURANCE
PO BOX 661023
DALLAS, TX 75266

CARRIER

PICA ☐ PICA ☐

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
☐	☐	☐	☐	☐	☐	☒

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22035F930

2. PATIENT'S NAME (Last Name, First Name, Middle Initial):

3. PATIENT'S BIRTH DATE SEX:

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street):

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous): YES ☐ NO ☒

a INSURED'S DATE OF BIRTH MM DD YY: SEX F ☒

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☒ NO ☐ PLACE (State): MI

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes,* return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 10/31/11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 08 19 11 — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) INJURY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: TERRY REZNICK D.O.

17a.

17b. NPI 1295874451

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20 OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 847.9 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 09 01 11	09 01 11	11		97035	GP	1	60.00	1		NPI	SONI
2 09 02 11	09 02 11	11		97010	GP	1	60.00	1		NPI	SONI
3 09 02 11	09 02 11	11		97032	GP	1	60.00	1		NPI	SONI
4 09 02 11	09 02 11	11		97035	GP	1	60.00	1		NPI	SONI
5 09 08 11	09 08 11	11		97010	GP	1	60.00	1		NPI	SONI
6 09 08 11	09 08 11	11		97032	GP	1	60.00	1		NPI	SONI

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
80-0503391	☒ ☐	JOHWI000 1343	☒ YES ☐ NO	$ 360.00	$	$ 360.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
09/19/11
SONI
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
NEW ERA PT SERVICES
G 4007 W. COURT ST. SUITE G2
FLINT, MI 48532
a. 1336469139 b.

33 BILLING PROVIDER INFO & PH. # (810)230-0444
NEW ERA PT SERVICES
G 4007 W. COURT ST. SUITE G2
FLINT MI 48532
a. 1336469139 b.

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APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

KMRPPT0050785

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM INSURANCE
PO BOX 661023
DALLAS, TX 75266

CARRIER

PICA ☐ PICA ☐

1. MEDICARE ☐ (Medicare #)	MEDICAID ☐ (Medicaid #)	TRICARE CHAMPUS ☐ (Sponsor's SSN)	CHAMPVA ☐ (Member ID#)	GROUP HEALTH PLAN ☐ (SSN or ID)	FECA BLK LUNG ☐ (SSN)	OTHER ☒ (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22035F930

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐ 8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	7. INSURED'S ADDRESS (No., Street)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☒ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX: M ☐ F ☒
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M ☐ F ☐	b. AUTO ACCIDENT? ☒ YES ☐ NO PLACE (State): MI	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☒ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO *If yes,* return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

SECOND FOLD

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: TERRY REZNICK D.O.	17a. 17b. NPI 1295874451	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 8470 3. 2. 847.1 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
1 09 02 11 09 02 11	11		97035	GO	12	60.00	1		NPI	RUTLEDGE
2 09 02 11 09 02 11	11		97124	GO	12	60.00	1		NPI	RUTLEDGE
3 09 08 11 09 08 11	11		97010	GO	12	60.00	1		NPI	RUTLEDGE
4 09 08 11 09 08 11	11		97014	GO	12	55.00	1		NPI	RUTLEDGE
5 09 08 11 09 08 11	11		97035	GO	12	60.00	1		NPI	RUTLEDGE
6 09 08 11 09 08 11	11		97124	GO	12	60.00	1		NPI	RUTLEDGE

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
80-0503391 ☐ ☒	JOHWI000 1344	☒ YES ☐ NO	$ 355.00	$	$ 355.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 11/11/10 RUTLEDGE SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT, MI 48532 a. 1336469139 b.	33. BILLING PROVIDER INFO & PH. # (810)230-0444 NEW ERA PT SERVICES G 4007 W. COURT ST. SUITE G2 FLINT MI 48532 a. 1336469139 b.

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APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

KMRPPT0050885